MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

77e 8e 10793

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above piece of death? 10 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 404 Diamond Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES ANDERSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7-24-1904

8. AGE: Years	Months	Days	If less than one day
43	4	8	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: John Anderson

FATHER — 13. Birthplace: ?

MOTHER — 14. Maiden name: Mary Pongee

MOTHER — 15. Birthplace: ?

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 13, 1947 (month) (day) (year)

Cemetery or crematory: Western Star

Location: Catonsville Md.

18. Funeral director: Mrs Katie R. Williams

Address: 322 N Schroeder St

19. 12/10 1947 (Date rec'd by registrar) H W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8th 19 47 at 3:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2nd 19 47 to December 8th 19 47 and that I last saw him alive on December 8th 19 47

Immediate cause of death	DURATION
Exhaustion Delirium	
Due to:	Known to us since 12/2/47
Due to:	
Other conditions: Alcoholic Deterioration	Known to us since 12/2/47

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquarten M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 12/8/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

10794

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

~~Hospital, Institution,~~ or street address where death occurred: Bayside Beach Road

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A.A.

City or town: Bodkin Creek

(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 243 R.F.D. #2

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME WILLIAM A. ANDERSON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: SARAH E. ANDERSON

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 7th 1879

8. AGE: Years	Months	Days	If less than one day
68	0	11	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: FISHERMAN

11. Industry or business: Self

FATHER 12. Name: George Anderson

13. Birthplace: Md.

MOTHER 14. Maiden name: Rachel (Unknown)

15. Birthplace: Md.

16. Informant: Sarah Anderson

Address: R.F.D. #2 Box 243 Bodkin Creek

17. Burial, cremation, or removal. Which? Burial Date thereof 12/22/47 (month) (day) (year)

Cemetery or crematory: Western

Location: Baltimore Md

18. Funeral director: William Cook Inc

Address: 1217 St. Paul St.

19. Dec. 19 1947 (Date rec'd by registrar) G. W. Fredrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1947 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20 1947 to Dec. 18 1947 and that I last saw him alive on Dec. 17 1947

Immediate cause of death	DURATION
Degenerative Cardio Vascular Disease	5 years
Due to: Myocarditis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Pasadena Md. Date signed 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

10795

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 yrs

Hospital, institution, or street address where death occurred:
Mayo

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

ALICE V. BALL

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Richard D. Ball

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 21, 1859

8. AGE:	Years	Months	Days	If less than one day
	88	8	13	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: none

FATHER
12. Name: James W. Matchett
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Unk.
15. Birthplace

16. Informant: Thomas B. Ball
Address: Mayo, Post Office, Mayo A.A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-6-47 (month) (day) (year)

Cemetery or crematory: Mayo Memorial Cemetery

Location: Mayo, A.A. Co, Maryland

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Maryland

19. Dec. 6, 19 47 Edward Collemore
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 4 19 47 at 7 Da M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 19 44 to Dec 4 19 47 and that I last saw h.. alive on Dec. 3 19 47

Immediate cause of death	DURATION
Arteriosclerosis cardio-vascular disease	20 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

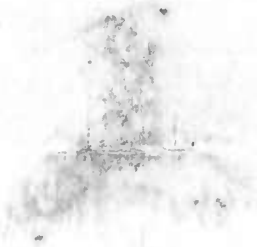
23. SIGNATURE: S. Bowsouch MD
M. D. or other

Address: Annapolis Md Date signed 12/5/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b

10796

29

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years, 11 months, 24 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 27 years, 11 months, 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Near Chestertown
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war: N

3.(a) FULL NAME

WILLIAM BARLOW

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
73	?	?	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: James Barlow
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/12-47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Asylum Hospital

Address

19 Dec 12 1947 (Date rec'd by registrar)

E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3rd 1947 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1941, to December 3 1947 and that I last saw him alive on December 3rd 1947

Immediate cause of death	DURATION
Cancer of the stomach	1 month
Due to	
Due to	
Other conditions: Manic Depressive Psychosis, Manic Type, Known to us since 10/1941	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Cancer of the stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of .....

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jacob Amgeretten M. D.
M. D. or other

Address: Crownsville, Maryland Date signed: 12/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10797

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 704 State St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Saphia Anna Barry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Walter F. Barry

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 30th 1899

8. AGE:

Years	Months	Days	If less than one day
48	0	22	hrs. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER

12. Name: George Schulthiss

13. Birthplace: New York City, N.Y.

MOTHER

14. Maiden name: Kiel

15. Birthplace: Baltimore, Md.

16. Informant: Walter F. Barry

Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/24/47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor, Jr.

Address: Annapolis, Md.

19. Dec. 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1947 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947, to dec 21 1947 and that I last saw her alive on dec 21 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 Months
Due to	
Due to	
Other conditions: Chr Bronchitis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Geo C Boeck M. D. or other

Address: Annapolis Md Date signed 12-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10798

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 6 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 7 months, 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309 N. Stricker
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: WILLIAM BUSH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Clara Bush
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5-7-1884

8. AGE: Years	Months	Days	If less than one day
63	7	9	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Porter
11. Industry or business:

FATHER
12. Name: John Bush
13. Birthplace: Virginia

MOTHER
14. Maiden name: Evelyn Green
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-1947 (month) (day) (year)
Cemetery or crematory: Asbury Memorial
Location:

18. Funeral director: Mrs Katie R. Williams
Address: 322 N. Schroeder St.

19. Dec 20 1947 (Date rec'd by registrar) H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16th 1947, at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10th 1947, to December 16th 1947 and that I last saw him alive on December 16th 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	½ hour
Due to: General & Cerebral Arterios-	
clerosis, assoc. with Diabetes	
Due to: mellitis	Known to us
	since 5/10/1947
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Dorsey Carter M. D.
M. D. or other
Address: Crownsville, Maryland Date signed: 12/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46a

CERTIFICATE OF DEATH

Reg. Dist. No. 10799

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 ~~days~~ years
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A A Co.
City or town: Glen Burnie Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cutting Blvd. Thos Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Charles Merriwether Christian

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Grace Christian
6.(c) If alive, give age: 66 years
7. Birth date of deceased (mo., day, yr.): Dec 15-1876
8. AGE: Years: 70 Months: 11 Days: 23 If less than one day: hrs. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual occupation: Real Estate Developer
11. Industry or business: Real Estate
FATHER 12. Name: Dr. John Hunt Christian
13. Birthplace: Virginia
MOTHER 14. Maiden name: Alice Lawrence
15. Birthplace: Maryland
16. Informant: Mrs. Grace Christian (wife)
Address: Severna Park A A Co. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12 47 (month) (day) (year)
Cemetery or crematory: Lorraine
Location: Woodlawn Md.
18. Funeral director: Stewart Moran Co.
Address: 108 W Monument Ave.
19. Dec 11 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1947 at 6.30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 5 1947 to Dec 8 1947 and that I last saw him alive on Dec 8 1947

	DURATION
Immediate cause of death: Acute Dilatation Generalized Peritonitis	3 days 3 days
Due to: Carcinoma Sigmoid Colon	1 mo
Due to:	
Other conditions: Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C. Basil M. D. or other
Address: Annapolis Md Date signed: 12.8.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

10800

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: South Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yrs
Hospital, institution, or street address where death occurred:
South Haven
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: South Haven nr. Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: none
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: BONITA B. CLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis E. Clark
6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): December 15, 1904

8. AGE: Years: 43 | Months: | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Alamedo Co. California
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: none

FATHER
12. Name: Sherman Augustus Bishop
13. Birthplace: Main

MOTHER
14. Maiden name: Ella Maud Myrick
15. Birthplace: San Francisco, Calif

16. Informant: Mr. Louis E. Clark
Address: South Haven RFD Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1948 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: Ben L. Hopping and Son
Address: 170-172 West St. Annapolis, Md.

19. Jan. 3 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1947 at 7:15 P. M.

21. I CERTIFY that death occurred on the date above stated, Duration of disease
Postmortem Examination
Dec. 30 1947

Immediate cause of death	DURATION
Carcinoma of left breast	
Due to with metastasis into	
Due to lungs and axillary	
Other conditions glands	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John N. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 1-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10801

CERTIFICATE OF DEATH

Reg. Diat. No. 71

1. PLACE OF DEATH:

County: Anne Arundel

City or town: St Margarets

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: St Margarets

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roger Cleon Cowling

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Elizabeth C. Cowling

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 12 1871

8. AGE: Years: 76 Months: 8 Days: 2 If less than one day: ..... hrs. ..... min.

9. Birthplace: Alexander Va.

(Town, county, and state)

10. Usual occupation: Retired Minister

11. Industry or business

FATHER 12. Name: Edward Cowling

13. Birthplace: Va.

MOTHER 14. Maiden name: Mary C. Studds

15. Birthplace: New York

16. Informant: Phillip J. Cowling

Address: St Margarets G.A.C. Md.

17. Burial: Burial, cremation, or removal. Which?

Date thereof: Dec 16 1947 (month) (day) (year)

Cemetery or crematory: St Margarets

Location: St Margarets G.A.C. Md.

18. Funeral director: Joseph M. Taylor Son

Address: Annapolis Md.

19. Dec 14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 14 1947 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Dec 14 1947 and that I last saw him alive on Dec 14 1947

	DURATION
Immediate cause of death: Myocarditis Chr. Myocardial Insufficiency	7 yrs
Due to:	
Due to:	
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: George C. Bond M. D. or other

Address: Annapolis Md. Date signed: 12-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10802

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Ann Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
212 Duke Of Glouster St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Ann Arundel

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 212 Duke Of Glouster
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Annie Elizabeth Day

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife Perry Day

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 1873

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace Edge Water, Md. A.A.Co.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name John Curtis

13. Birthplace St. Marys Co. Md.

MOTHER 14. Maiden name Harriet Curtis

15. Birthplace Md.

16. Informant Rose Thompson

Address 212 Duke Of Glouster St.

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof Dec. 4, 1947
(month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18. Funeral director J.B. Johnson

Address Annapolis, Md. B.O. Box 162

19. Dec. 4, 47
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1947 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3, 1947 to Dec. 1, 1947 and that I last saw h.. alive on Dec 1, 1947

	DURATION
Immediate cause of death Apoplexy	2 days
Due to Hypertensive Cardio-Vascular Disease	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore H. Johnson M.D.
M. D. or other

Address 40 Northwest Street Annapolis, Md. Date signed 12/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Evidence for Chief Mo. of Records
Hanover. G 113 12/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d 10803

Reg. Diat. No. 25

1. PLACE OF DEATH:
County A. A. County
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
500 Rivesdale Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A. Co.
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 500 Riverside Rd - 25
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Leonard L. Dengo

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of ~~husband~~ or wife Sarah Ann Dengo
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 9 December 9, 1887

8. AGE: Years	Months	Days	If less than one day
60 59	11		hrs. min.

9. Birthplace Estonia
(Town, county, and state)
10. Usual occupation Master Mechanic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs. Sarah L. Dengo
Address 500 Riverside Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 11-47 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Belair Road
18. Funeral director Milton Schilling
Address 3914 Hanover St.

19. December 2 1947 Ida M. Whitson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2- 1947 at 11.45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1, 1947 to Dec 2 1947 and that I last saw him alive on Dec 2 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to hypertension cardiovascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Philip W. Hunter MD
M. D. or other
Address 302 Patapsco Av Date signed 12/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13b

10804

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Chesterfield

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Baldwin Ellershaw

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Eugenia K. Ellershaw

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby 7th 1864

8. AGE: Years	Months	Days	If less than one day
83	10	16	..... hrs. ..... min.

9. Birthplace: Yorkshire, England

(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: Robert B. Ellershaw

13. Birthplace: Yorkshire, England

MOTHER — 14. Maiden name: Mary Singleton

15. Birthplace: Yorkshire, England

16. Informant: Robert B. Ellershaw III

Address: Weems Creek, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/47 (month) (day) (year)

Cemetery or crematory: St. Stevens Cemetery

Location: A. A. Co. Md.

18. Funeral director: John M. Taylor

Address: Annapolis, Md.

19. Dec. 27 1947 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 23 1947, at 10 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to Dec 23 1947 and that I last saw h. alive on Dec 23 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	?
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. D. Kleaveland, M.D. M. D. or other

Address: Annapolis, Md. Date signed 12/26/47

10805

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Spa View Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Agnes Ellinghausen

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Herman C. Ellinghausen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3d 1903

8. AGE:

Years	Months	Days	If less than one day
44	8	9	..... hrs. ..... min.

9. Birthplace: Annapolis, A. A. Co., Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER

12. Name: William Hasbrook

13. Birthplace: Germany

MOTHER

14. Maiden name: Frances Wittkofsky

15. Birthplace: Germany

16. Informant: Mrs. Herman C. Ellinghausen

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/15/47 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor, Son

Address: Annapolis, Md.

19. Dec. 14, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 1947, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1947, to Dec 12 1947

and that I last saw her alive on Dec 11 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: George C. Boyle M. D. or other

Address: Annapolis Md. Date signed 12.14.47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10806

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 419 Fourth Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Helen B. Fiesler

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Edward E. Fiesler, Jr.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany. 7th 1897

8. AGE:

Years	Months	Days	If less than one day
60	11	12	..... hrs. ..... min.

9. Birthplace: Annapolis A. A. Co. Md.

(Town, County, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: John B. Suit

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Helena F. Dillingham

15. Birthplace: Maryland

16. Informant: Mrs. Edward E. Fiesler

Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/47 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis, Md.

19. Dec. 27 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1947, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 1945 to Dec 26 1947 and that I last saw her alive on Dec 26 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Hypertensive Cardiovascular disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John Suit M. D. or other

Address: Eastport Md. Date signed 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10807

1700

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County ANNE ARUNDEL, MD.
City or town FT. GEO. G. MEADE, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos
Hospital, institution, or street address where death occurred:
STATION HOSPITAL, FT. MEADE, MD.
How long in hospital or institution? 3½ days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County
City or town Ferrum
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME FRITH, LARNEY E

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 January 1922

8. AGE: Years	Months	Days	If less than one day
25	11	12	hrs. min.

9. Birthplace Ferrum, Virginia
(Town, county, and state)

10. Usual occupation Soldier

11. Industry or business

FATHER 12. Name Hubbard C. Frith
13. Birthplace Unknown

MOTHER 14. Maiden name Unknown
15. Birthplace

16. Informant Service Records of deceased
Address Ft Geo G Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 15 Dec 47 (month) (day) (year)
Cemetery or crematory Rocky Mt Funeral Home
Location Rocky Mt., Va.

18. Funeral director Lily & Zeiler, Inc
Address 403 S. Wolfe St., Balto, Md

19. 15 Dec (Date rec'd by registrar) 19 47 James N. Georgen CHARLES N. GOERGEN, Capt., MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Saturday, 13 December 1947 at 1:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Tuesday 9 Dec. 1947 to Saturday 13 Dec. 1947 and that I last saw h. alive on 13 December 1947

Immediate cause of death	DURATION
respiratory arrest - central	
in origin, vasomotor collapse	
Due to severe cerebral and midbrain	
damage	
Due to Subdural and multiple local	
hemorrhages about area of vital centers:	
Other conditions fx. dist'al, ⅓ fibula, right.	

(Include pregnancy within 3 months of death)

Major findings of operations Exploratory laparotomy performed Ft Meade Station Hosp - Non-traumatic cranial injuries Date of op. 10 Dec 47

Autopsy results No autopsy performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide struck by auto Date of 9 Dec 47
Where did injury occur? Annapolis Road Ft Meade Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) On Annapolis Rd. Ft. Meade Md.
Means of injury pedestrian struck by auto. Injured at work? In gen'l service

23. SIGNATURE George H. Millington, Capt. MC M. D. or other
Address Station Hosp. Ft G G Meade, Md. Date signed 13 Dec 47

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. 75

10808

1. PLACE OF DEATH: Anne Arundel Co Brooklyn
(a) ~~Baltimore City~~, Maryland
(b) Street address 101 Seventh Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 Seventh Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Gallion

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Peter Gallion
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1866

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr William Gallion
(b) Address 101 Seventh Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/47 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St.

18 (a) Funeral director John F Denny Sec
(b) Address 715 Eight St.

19 (a) 12/16/47 (Date rec'd by registrar) (b) A. W. Hedrick Dm Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1947 at 1 05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1947 to Dec 14 1947, and that I last saw her alive on Dec 14 1947.

Immediate cause of death	Duration
Pulmonary Congestion	2 wks
Due to Chronic Myocarditis	
Due to Hypertension Arteriosclerosis	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louise Miller M.D.
Address 101 Seventh Ave Date signed 12/15/47

12/15/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

VS 150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122a

10809

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6 Dogwood, Homaja Village

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Wade Gentry, Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 15th 1947

8. AGE:

Years	Months	Days	If less than one day
0	7	18	...hrs. ...min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER

12. Name: Wm Wade Gentry Sr.

13. Birthplace: Madison, N. Carolina

MOTHER

14. Maiden name: Jane Vann

15. Birthplace: Monroe N. Carolina

16. Informant: Wm W. Gentry, Sr.

Address: Homaja Village, Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/5/47 (month) (day) (year)

Cemetery or crematory: Naval Academy Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis Md.

19. Dec. 5 1947 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 Dec 1947 at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Dec 1947 to 3 Dec 1947 and that I last saw h.. alive on 3 Dec 47 19...

	DURATION
Immediate cause of death: Aspiration of gastric contents	10 Seconds
Due to: Strangulated inguinal hernia, right	5 hours
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Bloody fluid in hernial sac. Part of transverse colon & omentum and cecum

Date of op. 3 Dec 47

Autopsy results? Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jno. H. Hooten, M.D. M. D. or other

Address: 53 Cornhill St. Annapolis Md. Date signed: 4 Dec 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

10810

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A A.
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME Albert Bernardson Gibson

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 9 - 188~

8. AGE: Years 65 | Months 7 | Days 0 | If less than one day ... hrs. ... min.

9. Birthplace: Greenock (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Richard Macked Gibson
13. Birthplace: Cal. Co. Md.

MOTHER
14. Maiden name: Barbara Jane Catterton
15. Birthplace: Calvert Co. Md

16. Informant: Milton Gibson
Address: West River, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/4/47 (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Lothian Md.

18. Funeral director: T. A Hardesty & Son
Address: Galesville Md

19. 12/4 19 47 (Date rec'd by registrar) M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2 19 47 at 3:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 2 19 47, to Dec. 2 19 47
and that I last saw h... alive on Dec. 2 19 47

Immediate cause of death	DURATION
Cerebral hemmhage	
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. (M. D. or other)
Address: Lothian, Md. Date signed 12-2-47

3

Frost System

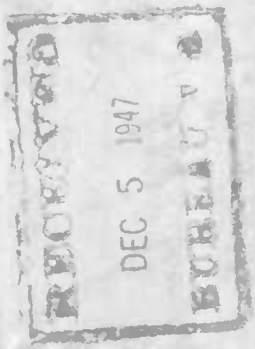
Mrs Emma Rawlings — Balt.

Mrs Rosie Carry — Penna.

Mrs James W Turner - Lothian

Brother Richard Mullar - Westport

~~Reception Hall~~



2 Thursday

9-10

47
19
28

36

Mr. Allen

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462

10811

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Ann Arundel

City or town Rural , Edgewater, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Ann Arundel

City or town Rural , Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Hattie Pearl Giles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife George Giles

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
52			..... hrs. ..... min.

9. Birthplace Greensboro, N.C.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name George Monroe

13. Birthplace Calvert, Co.

MOTHER 14. Maiden name Emma Monroe

15. Birthplace Calvert Co.

16. Informant William E. Thomas

Address Edgewater P.O., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 23, 1947 (month) (day) (year)

Cemetery or crematory Mt. Hope

Location Calvert Co., Md.

18. Funeral director J.B.Johnson

Address P.O.Box 462 Annapolis, Md.

19. Dec. 27 1947 (Date rec'd by registrar) Wm. Tomich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1947, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 18 1947, to Dec 20 1947 and that I last saw h.. alive on Dec 18 1947

Immediate cause of death Carcinoma of Stomach (?) — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. T. Talbert M.D.

M. D. or other

Address 17 Carroll Date signed 12-29-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10812

93c

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Catalina Beach (Pasadena P. O.)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (Westport)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2424 Annor Court
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CHARLES EDWARD GOSS

3.(b) Social Security Number: 283 07 5878

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret A. Goss (Nee Wilson) 6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 11, 1893.

8. AGE: Years	Months	Days	If less than one day
54	8	28	....hrs. ....min.

9. Birthplace: Louistown, Mifflin Co., Penna.
(Town, county, and state)

10. Usual occupation: Machinic

11. Industry or business: Easten Stainless Steel

FATHER — 12. Name: Harry H. Goss

13. Birthplace: McClure, Penna.

MOTHER — 14. Maiden name: Margaret Stuck

15. Birthplace: McClure, Penna.

16. Informant: Mrs. Margaret A. Goss

Address: Catalina Beach (Pasadena Md.RFD)

17. Shipper (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Mt. Union, Pennsylvania

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 12-10-47 (Date rec'd by registrar) L. A. Brit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9 1947, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8 1947 to Dec. 9 1947 and that I last saw him alive on Dec. 8 1947

Immediate cause of death	DURATION
Rheumatic Cardio Vascular Disease	5 Months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other

Address: Aurora Beach, Md. Date signed: 12/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

no record

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10813

Reg. Dist. No. 21

1. PLACE OF DEATH: County A. A. City or town Earleigh Heights (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County A. A.
City or town Earleigh Heights (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lyndia Carroll Griffin

3.(b) Social Security Number

4. Sex Fem
5. Color or race Colored
6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife —
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 2, 1947
8. AGE: Years Months 8 Days If less than one day hrs. min.
9. Birthplace Earleigh Heights AA Co (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name James C. Griffin
13. Birthplace West Va
MOTHER 14. Maiden name Annie May Jones
15. Birthplace A. A.
16. Informant Annie May Jones
Address Earleigh Heights
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31 1947 (month) (day) (year)
Cemetery or crematory 1st Baptist Church Cem.
Location Earleigh Heights
18. Funeral director J. B. Johnson
Address Annapolis
19. 12/31 1947 (Date rec'd by registrar) L. J. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/47 19 , at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/24 1947 to 12/29/47 19
and that I last saw her alive on 12/29/47 19

	DURATION
Immediate cause of death Bronchopneumonia	3 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John [illegible] M. D. or other
Address Glen Burnie Date signed 12/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10814

Reg. Dist. No. 22

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Anne Arundle
City or town Dorsey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A.A. Co.
City or town Dorsey
(If outside city or town limits, write RURAL and give nearest town)
Street No. Forest Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John William Grimes

3. (b) Social Security Number

4. Sex M | 5. Color or race W | 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Nina M. Grimes
6.(c) If give, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 28 1873

8. AGE: Years 74 | Months 5 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual occupation Brakeman

11. Industry or business Retired B&O R.R.

FATHER
12. Name Amon Grimes
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Lowndes
15. Birthplace Pa.

16. Informant Mrs. Nina M. Grimes
Address Forest Ave, Dorsey, Md.

17. Burial Date thereof Dec. 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Meadowridge Mem. Park
Location Dorsey, Md.

18. Funeral director Geo. R. Gambrill & Son
Address Laurel, Md.

19. Dec 12 1947 Edna Haskell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 1947, at 10:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1946 to Dec. 10th 1947
and that I last saw h alive on Dec. 10th 1947.

	DURATION
Immediate cause of death Acute Cardiac Insuff. with Pulmonary oedema.	24 hrs.
Due to Hypertensive Cardio-Vas. Disease	1 hr.
Due to Arterio-sclerosis	5 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M. D.
M. D. or other
Address Savage, Md. Date signed 12/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10815

83a

28

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 yrs. 7 mos.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 7 yrs. 7 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Poorhouse, Carter's Home

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: GROSS - MARY JANE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	negro	single

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE: Years	Months	Days	If less than one day
About 75 Unknown			hrs. min.

9. Birthplace: Anne Arundel County (Town, county, and state)

10. Usual occupation: None

11. Industry or business: --

FATHER 12. Name: Henry Wilms

13. Birthplace: Maryland

MOTHER 14. Maiden name: Lisa Wilson

15. Birthplace: Maryland

16. Informant: Hospital records

Address: Crownsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 12-27-47 (month) (day) (year)

Cemetery or Crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt. Hospital

Address: Crownsville Md

19. (Date rec'd by registrar) 12/27 19 47 E. Joyce Rose Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 19 47 at 5:00 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to Dec. 15 19 47 and that I last saw her alive on Dec. 15 19 47

Immediate cause of death: Known to us DURATION

Cerebral Hemorrhage since 12/14/47

Due to:

Due to:

Known to us since

Other conditions: Psychosis with mental defi- 5/29/40

ciency and paranoid ideas

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred Marquette M.D. M. D. or other

Address: Date signed

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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10816

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 2 months, 23 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 3 years, 2 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County:
City or town: Selbyville
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. # 2 Box 154
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: FRANK HANDY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1872

8. AGE:

Years	Months	Days	If less than one day
75	?	?	hrs. min.

9. Birthplace: Selbyville, Del. (Town, county, and state)
10. Usual occupation: Schoolteacher
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace:

MOTHER
14. Maiden name: Rachel Jane Pernell
15. Birthplace: Md.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1947 (month) (day) (year)
Cemetery or crematory: Longs
Location: Near Selbyville, Del.

18. Funeral director: J.B.Johnson
Address: Annapolis, Md. [illegible], Md.

19. Dec. 4 1947 E.F. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1rst 1947, at 2:35P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 8th 1944, to December 1st 1947 and that I last saw h... im ...alive on December 1st 1947

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	Known to us since 9/8/1944
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 9/8/1944

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jacob Margenstern M. D. (M. D. or other)
Address: Crownsville, Maryland Date signed: 12/1/47

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Claffy 167 10817

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
66 Larkins
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 65 Larkins st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Richard Harris
3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lucy Harris
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 7 1902

8. AGE: Years	Months	Days	If less than one day
45	6	16	hrs. min.

9. Birthplace: Annapolis A.A.Co., Md.
(Town, county, and state)
10. Usual occupation: Brewer
11. Industry or business: Brewer Laundry
FATHER 12. Name: Abel Harris
13. Birthplace: Md
MOTHER 14. Maiden name: Mary Larkins
15. Birthplace: Annapolis
16. Informant: Mary Johnson
Address: 73 Clay st Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 28 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J B Johnson
Address: Annapolis
19. Dec. 28 1947 (Date rec'd by registrar) W. T. Franck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 23 1947 at 6 15 A M
21. I CERTIFY that death occurred on the date above stated: Post-mortem Examination Dec. 23 1947

Immediate cause of death	DURATION
Hemorrhage from incised wounds of face	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of 12/23/47
Where did injury occur? Annapolis (City or town) Anne Arundel (County) Md. (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: Sharp instrument Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1390

10818

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Anne Arundel
County
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 10½ Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 57 Calvert Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thelma Jaunita Holland

3.(b) Social Security Number: 216-28-0771

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 24, 1924

8. AGE: Years	Months	Days	If less than one day
23	1	23	hrs. min.

9. Birthplace: Annapolis Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Harry Holland
13. Birthplace: Annapolis, Maryland

MOTHER
14. Maiden name: Florence Elizabeth Carroll
15. Birthplace: Annapolis, Maryland

16. Informant: Florence Elizabeth Carroll
Address: 57 Calvert Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-21-1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Dec. 19, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 1947, at 11:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11, 1947, to Dec 17, 1947
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute Appendicitis	10½ hrs.
& Peleri Abscess	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ... Injured at work?

23. SIGNATURE: Theodore G. Johnson M.D.
M. D. or other
Address: 40 Northwest Street Date signed: 12/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 10589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 23 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 5 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 923 Argyle Ave. (If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: CLIFFORD HOLT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife: Unknown to us

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8/3/1899

8. AGE: Years	Months	Days	If less than one day
48	4	17	hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER — 12. Name: Ashley Holt

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Eddie Durham

15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which? burial Date thereof 12-23-47 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Sister Hospt

Address: Crownsville Md

19. (12/47) 47 (Date rec'd by registrar) E.F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20th 19 47, at 2:00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27th 19 47, to December 20th 19 47 and that I last saw him alive on December 20th 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	Known to us since 12/17/47
Due to:	
Due to:	
Other conditions: Paranoid Conditions	Known to us since 6/27/47

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Purulent Mengitis due to brain abscess

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---------- Date of:

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: Injured at work?

23. SIGNATURE: Jacob Bergenstock M.D. M. D. or other

Address: Crownsville, Maryland Date signed: 12/20/47


RECEIVED
DEC 30 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 10834

1. PLACE OF DEATH:

County: A. A. County

City or town: Solley Road (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A. County

City or town: Glendennie P.O. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Solley Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Michael Houdek

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widower

6.(b) Name of ~~husband~~ or wife: Marie Houdek

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 29-1881

8. AGE: Years: 66 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Czechoslovakia (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Self

FATHER — 12. Name: James Houdek

FATHER — 13. Birthplace: Czechoslovakia

MOTHER — 14. Maiden name: Anna Tieha

MOTHER — 15. Birthplace: Czechoslovakia

16. Informant: Mrs. Youngbare

Address: Solley Rd Glendennie P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 6-47 (month) (day) (year)

Cemetery or crematory: Cedar Hill

Location: Gov. Ritchie Highway

18. Funeral director: Milton Schilling

Address: 3914 Hanover St. -25-

19. Dec. 5 1947 (Date rec'd by registrar) Ida M. Johnston Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1947, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1947 to Dec 3 1947 and that I last saw him alive on Dec 1 1947

Immediate cause of death	DURATION
Cer. T.B	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Samuel Rubin M.D. M. D. or other

Address: 203 Baltimore St. Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct as age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

10821

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Ann Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3 Pleasant Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Ann Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Pleasant Court #3

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Catherine Ireland Hunt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife Arthur Hunt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 22, 1896

8. AGE: Years	Months	Days	If less than one day
51	4	6	..... hrs. ..... min.

9. Birthplace West River, Md. A.A.Co.

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Nelson Ireland

13. Birthplace West River, Md.

MOTHER 14. Maiden name Matilda (unknown)

15. Birthplace Md.

16. Informant James Hunt

Address 3 Pleasant Court

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1947 (month) (day) (year)

Cemetery or crematory Brewer Hill

Annapolis, Md.

Location

18. Funeral director J.B.Johnson

Address Annapolis, Md. P.O.Box 462

19. Dec. 31 1947 (Date rec'd by registrar) C. O. Church Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947, to Dec 27 1947 and that I last saw h[illegible] alive on Dec 27 1947

Immediate cause of death	DURATION
Hypertensive Cardio Vascular Disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. T. Talley, M. D.

M. D. or other

Address 17 Conduit Date signed 12-30-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10822

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? five years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? five years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 938 North Stricker Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: JACKSON - DELLA

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife: Henry Jackson
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): unknown 1890

8. AGE: Years	Months	Days	If less than one day
57			..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: Samuel Greene
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elsie Gore
15. Birthplace: Virginia

16. Informant: Hospital records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/23/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Harpers Ferry West Va.

18. Funeral director: John H. Tayler Son
Address: Annapolis Md.

19. Dec. 21 st. 1947 E.J. Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20 19 47 at 4:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10, 1942 to December 20 1947 and that I last saw her alive on December 20 1947

Immediate cause of death	DURATION
Tuberculosis of the lungs	
Known to us since November 14, 1947	
Due to:	
Due to:	
Other conditions: Involutional psychosis	
known to us since November 10, 1942	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 12/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10823

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years, 8 months, 3 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 5 years, 8 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: Mechanicsville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: GLADYS JOHNSON

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: James Johnson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Unknown to us 1920
8. AGE: Years: 27 Months: ? Days: ? If less than one day: hrs. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business:
FATHER 12. Name: Webster Tolson
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Gant
MOTHER 15. Birthplace: Maryland
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial, cremation, or removal. Which? Burial Date thereof 12/17/47 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md.
18. Funeral director: State Hospital
Address: Crownsville Md
19. (Date rec'd by registrar) 12/17/47 Registrar: E J Joyce

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17th 1947 at 1:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 14th 1942 to December 17 1947 and that I last saw her alive on December 17th 1947
Immediate cause of death: Pulmonary Tuberculosis — DURATION: Known to us since 12/3/1947
Due to:
Due to:
Other conditions: Schizophrenia-Catatonic Type — Known to us since 4/14/42
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D. (M. D. or other)
Address: Crownsville, Maryland Date signed: 12/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

10824

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Waterbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: pronounced dead on arrival
How long in hospital or institution? in Annapolis Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waterbury Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Helen Marie Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	married

6.(b) Name of husband or wife: Clarence M. Johnson
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): March 14, 1923

8. AGE:

Years	Months	Days	If less than one day
24	9	5	hrs. min.

9. Birthplace: Waterbury, A. A. County, Md
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: Housework
MOTHER FATHER
12. Name: Joseph Parker
13. Birthplace: Chesterfield, Md.
MOTHER
14. Maiden name: Irene Collins
15. Birthplace: Waterbury, Md
16. Informant: Clarence M. Johnson
Address: R.F.D. Crownsville P.O., Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23 1947 (month) (day) (year)
Cemetery or crematory: John Wesley
Location: Waterbury, Md
19. Funeral director: J.B. Johnson
Address: Annapolis P.O. Box 102
19. Dec. 22 19 47 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 19 47 at 7 25 P. M

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination Dec. 19 19 47

	DURATION
Immediate cause of death: Fracture of skull	sudden
Due to: Hemorrhage	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 12-19-47
Where did injury occur? Waterbury (City or town) Anne Arundel (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Waterbury Road
Means of injury: auto ran into tree Injured at work? No

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 12-19-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Register [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland A.A. Co.
(b) Street address
(c) Hospital or institution:
Emergency Hospital, Annapolis, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 10825
(a) State Md. (b) County Anne Arundel Co.
(c) City or town Jewell
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Basil Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
27			hr. min.

9. Birthplace Jewell (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Arthur C. Creek
13. Birthplace Maryland

MOTHER
14. Maiden Name Elsie Daisy Gray
15. Birthplace Calvert Co. Md.

16 (a) Informant Basil Johnson
(b) Address Jewell

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4. 1948 (month) (day) (year)
(c) Cemetery or crematory Union Methodist Cem
Location Pig Neck Md

18 (a) Funeral director D. C. Saunders & Son
(b) Address Galesville Md

19 (a) JAN 3 - 1948 (Date rec'd by registrar) (b) Hunting to Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1947, at 3 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary edema due to
acute congestive heart disease
Due to 95c
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-11-47 ? 9 a. M.
(b) Where did injury occur? Jewell- Md. Anne Arundel Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger- fell out door open

23. Signature Earl L. Kemp M.D. (Medical Examiner)
Date signed 1-1-48

VS 151

VS. A15

Dr Roller

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

46b

10826

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis Neck, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Annapolis Neck
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Richard Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Priscilla Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 28, 1877

8. AGE: Years	Months	Days	If less than one day
70	10		hrs. min.

9. Birthplace: A.A.Co. Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Daniel Johnson
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Nancie Brown
15. Birthplace: Md.

16. Informant: Sarah Johnson
Address: 15 Taylor Street, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31, 1947 (month) (day) (year)
Cemetery or crematory: Annapolis Neck
Location: Annapolisneck, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis, Md. P.O. Box 462

19. Dec. 31 19 47 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 19 47 at 11:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 13th 19 47 to Dec 28 19 47 and that I last saw him alive on Dec 24 19 47

Immediate cause of death	DURATION
Occlusion of pyloric portion of stomach	4 weeks
Due to: tumor of pyloric region	
Due to: Tumor: Probably malignant according to xray report	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: not done Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edith Roller M.D.
M. D. or other
Address: 42 State Circle Date signed: 12-29-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

10827

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years.
Hospital, Institution, or street address where death occurred: Hammonds Ferry Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Linthicum
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs. Eugene Kaiser

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: Hedwig Theis
6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): January 11 - 1878

8. AGE:

Years	Months	Days	If less than one day
69	10	25	hrs. min.

9. Birthplace: Germany, Europe (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business
FATHER 12. Name: Karl Kaiser
13. Birthplace: Germany
MOTHER 14. Maiden name: Frederika Kohler
15. Birthplace: Germany
16. Informant: Mrs. E. Kaiser, wife
Address: Linthicum, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/47 (month) (day) (year)
Cemetery or crematory: Moreland Memorial Park
Location: Taylor Ave.
18. Funeral director: Clarence F. Hoffmann
Address: 1639 Broadway.
19. 12/8 19 47 A. W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 19 47, at 9 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/6/47 19 to 12/6/47 19 and that I last saw h[illegible] alive on 12/6/47 19

Immediate cause of death	DURATION
Coronary Occlusion	sudden.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Fowler, Md. M. D. or other
Address: Glen Burnie, Md Date signed: 12/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

10828

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Pasadena P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riviera Beach
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Frazeiska Kiesenbauer

3.(b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: William Kissenbauer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): January 29, 1863
8. AGE: Years: 84 Months: 10 Days: 28 If less than one day: hrs. min.
9. Birthplace: Bohemia (Town, county, and state)
10. Usual occupation: retired housewife
11. Industry or business: home
FATHER 12. Name: Wilhelm Tischler
FATHER 13. Birthplace: Bohemia
MOTHER 14. Maiden name: Franziska Tischler
MOTHER 15. Birthplace: Bohemia
16. Informant: Mr. Rudolph Kiesenbauer
Address: Haslem Rd. Riviera Beach
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1947 (month) (day) (year)
Cemetery or crematory: Meadow Ridge Memorial Park
Location: Washington Blvd. Elkridge
18. Funeral director: Frederick A. Cole
Address: 1500 W. Lombard St.
19. Dec 29 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 19 47 at 3:00 p.m.
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased~~ Post mortem Examination 19
~~and that I last saw him alive on~~ Dec. 16 1947

Immediate cause of death	DURATION
Suicide by	
Due to hanging	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Dec 16, 47
Where did injury occur? Riviera Beach (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: hanging Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or Other
Address: Annapolis Md Date signed: 12/26/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10829

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: dead on arrival
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Woodland Beach
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Marie Kimmel

3.(b) Social Security Number

4. Sex: female
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Jos. F. Kimmel
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jany 31st 1886

8. AGE: Years: 61 | Months: 10 | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pittsburg Pa
(Town, county and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: William Loschelder
13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Joseph F. Kimmel
Address: Edgewater A & G Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 13th 1947 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: Robert Nattingly
Address: 131 11th St. SE Washington, D.C.
19. Dec. 10th 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 1947 at 2 P. M.
21. I CERTIFY that death occurred on the date above stated, ~~and attended the deceased from ..... to .....~~
Post mortem Examination
~~Last saw deceased alive~~ Dec. 10, 1947

	DURATION
Immediate cause of death	
Acute Dilatation of Heart	Sudden
Due to: Chronic myocarditis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John N. Claffy M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 12-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836 No. 10830

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: 205 7th avenue S. W.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 439 Whitridge Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Gerbert Kline

3.(b) Social Security Number: No

4. Sex: M
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of ~~husband~~ or wife: Mary Kelly
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Sept. 23 - 1865

8. AGE: Years	Months	Days	If less than one day
82	2	28	... hrs. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Retired engineer on
11. Industry or business: P. R. R.

FATHER
12. Name: John Kline
13. Birthplace: ?

MOTHER
14. Maiden name: Rachel Priscilla Gerbert
15. Birthplace: ?

16. Informant: Mrs Helen Crawford (Daughter)
Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal, Which?)
Date thereof: DEC. 23, 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 12/23 1947 (Date rec'd by registrar) L. J. D'Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21st 1947, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral Thrombosis	Sudden
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: No Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? ...

23. SIGNATURE: Gustave H. Tarabeskus
acting deputy med. examiner M. D. or other
Address: Glen Burnie, Md. Date signed 12/22/47

10831

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

111a

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County A.A. Co

City or town ~~Pasadena~~ Emergy Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: Annapolis Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Pasadena A.A. Co. Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Knopp

3. (b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., dy., yr.) April 7 1863

8. AGE: Years	Months	Days	If less than one day
84	8	21	hrs. min.

9. Birthplace Shadyside A.A. Co Md.
(Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Joseph Knopp

13. Birthplace Germany

MOTHER 14. Maiden name ELLEN COLLINS

15. Birthplace Edgewater A.A. Co. Md.

16. Informant Edward Hardesty

Address Galesville Md 3-1947

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30 1947 (month) (day) (year)

Cemetery or crematory Knopp Cemetery

Location Deale, Md.

18. Funeral director J. A. Hardesty & Son

Address Galesville Md

19. Dec. 29 1947 (Date rec'd by registrar) W. L. Brinch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1947, at 19 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 26 1947, to Dec. 28 1947

and that I last saw him alive on Dec. 27 1947

Immediate cause of death	DURATION
pulmonary embolus	
Due to prostatectomy	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emil H. Nilsen M.D.
M. D. or other

Address Lothian, Md. Date signed 12-29-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 10832

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 minutes
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Md County Anne Arundel
City or town Jessup Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fort Meade Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Larry L. Mills

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	B	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 - 1947

8. AGE:

Years	Months	Days	If less than one day
	4	7	hrs. min.

9. Birthplace Washington D C (City, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Warren Mills
13. Birthplace Prince Geo Co. Md

MOTHER
14. Maiden name Grace Savoy
15. Birthplace Prince Geo Co. Md.

16. Informant Grace Savoy
Address Hall. Sta. Md.

17. Burial Date thereof Dec. 13 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Nebo
Location Queen Anne
18. Funeral director C. P. Johnson
Address Annapolis

19. Dec. 12 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11-47 19 noon at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 11-47 19 to Dec 11-47 19
and that I last saw alive on Dec 11-47 19

Immediate cause of death	DURATION
Acute Broncho Pneumonia	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE
M. D. or other
Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

10833

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - near Riva
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Home - Riva Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - near Riva
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Riva Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Edward William Minte

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Ella Minte

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 3 1882

8. AGE: Years	Months	Days	If less than one day
65	10	12	..... hrs. ..... min.

9. Birthplace: N.Y. (Town, county, and state)

10. Usual occupation: Painter

11. Industry or business

FATHER
12. Name: PETER MINTE
13. Birthplace: Germany.

MOTHER
14. Maiden name: AGATHA ?
15. Birthplace: Germany.

16. Informant: Ethel M. McKinstall
Address: 4525 Illinois ave. N.W. Wash. D.C.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 12 (month) 17 (day) 1947 (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: Joe Gawler Sons

Address: 1756 Penn ave. N.W. Wash. D.C.

19. Dec. 15 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15 19 47, at 8 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased from~~ ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Cerebral hemorrhage

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D.
M. D. or other Acting M. E.

Address: Annapolis, Md. Date signed Dec. 15, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10834

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: C.C. Co Md

City or town: Manchester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: C.C. Co Md

City or town: Winchester

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter T. Moon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, ~~widowed~~, or ~~divorced~~
Male	White	Married

6.(b) Name of husband or ~~wife~~ of Nannie J Moon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31 1868

8. AGE: Years 79 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Balto (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Shoe business

FATHER 12. Name Richard Moon

13. Birthplace Balto

MOTHER 14. Maiden name Laura Thomas

15. Birthplace Md.

16. Informant Nannie J Moon

Address Winchester C.C. Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 2 1948 (month) (day) (year)

Cemetery or crematory Greenmount Cem

Location Greenmount & Clifton Sts

18. Funeral director John C Moran

Address 3000 E Balto St

19. Jan 1, 1948 (Date rec'd by registrar)

W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1947 at 3 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June or 1939 to Dec 31 1947 and that I last saw him alive on Dec 31 1947

Immediate cause of death	DURATION
Acute Dilatation & Heart	Few Hrs.
Due to Myocarditis Chr.	8 Years
Due to Arteriosclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Basil M. D. or other

Address Annapolis Md Date signed 12. 31. 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10835

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 6 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: R.F. # 2 near Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.#2 Box 610 near Annapolis
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Angerus Morris

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Mary Morris

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): October 20, 1882

8. AGE: Years	Months	Days	If less than one day
65	1	18	____ hrs. ____ min.

9. Birthplace: White Stone Virginia
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: None

FATHER — 12. Name: Austin Morris

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Joseph Linsy Morris

Address: R.F.#2 Box 610

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12- 11-1947 (month) (day) (year)

Cemetery or crematory: Broad Neck Skidmore Md.

Location: Broad Neck Church- Skidmore Md.

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Dec. 11 1947 (Date rec'd by registrar)

W. O. Branch W Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1947, at 7.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 8 1947 to Dec. 8 1947 and that I last saw h.. alive on Dec. 8 1947

Immediate cause of death	DURATION
Coronary thrombosis	1½ hrs
Due to: arteriosclerotic cardio-vascular disease	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: S Bozman M D
M. D. or other

Address: Annapolis Md Date signed 12/10/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH: A. A. Co.

County ....

City or town Hanover, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ....

Hospital, institution, or street address where death occurred: Dorsey - Harmans Rd.

How long in hospital or institution? ....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Hanover, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Dorsey - Harmans Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war ....

3.(a) FULL NAME Bernard Mundell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col.	married

6.(b) Name of husband or wife ....

7. Birth date of deceased (mo., day, yr.) 7/5/95

6.(c) If alive, give age .... years

8. AGE: Years 52 | Months 5 | Days 25 | If less than one day .... hrs. .... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer & farmer

11. Industry or business ....

FATHER 12. Name Bernard Mundell

13. Birthplace Maryland

MOTHER 14. Maiden name Bessie Mundell

15. Birthplace Maryland

16. Informant Bessie Mundell

Address Dorsey Road, Hanover, Md

17. Jan. 2, 1948 (Burial, cremation, or removal. Which?) Date thereof Jan 2 - 48 (month) (day) (year)

Cemetery or crematory ....

Location Dorsey Road, Hanover, Md

19. Funeral director Mrs. Katie R. Williams

Address 322 W. S. Chorden Street

19. Jan 2 1948 (Date rec'd by registrar) Velma Kraft Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30th 1947 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 23rd 1947, to Dec. 30 1947 and that I last saw him alive on Dec. 30th 1947

Immediate cause of death	DURATION
Cerebral Haemorrhage	1 wk
Due to Hypertension	3 yrs
Due to Arterio-sclerosis	3 yrs
Other conditions ✓	

(Include pregnancy within 3 months of death)

Major findings of operations .... Date of op. ....

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE Frank Shipley, M.D. M. D. or other

Address Savage, Md. Date signed 1/2/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
FEB 16 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

10836

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: A.A.County
City or town: Jessups, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Maryland House of Correction
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balt.
City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 589 Baker Street
(If rural, give LOCATION)
2.(a) If veteran, name war: √

3.(a) FULL NAME: Morris Nugent

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col'd	Married

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years	Months	Days	If less than one day
51			..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)
10. Usual occupation: "
11. Industry or business: "
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Unknown
15. Birthplace
16. Informant: Md House of Correction Md
Address: Jessup
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 30-47 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Jessup Md
18. Funeral director: H.B.Cealins
Address: Jessup Md
19. Dec 29 1947 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7, 1947 at 7:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 27th 1947 to Dec. 7th 1947 and that I last saw him alive on Dec. 6th 1947

Immediate cause of death	DURATION
Acute Cardiac Dil.	Instant
Due to Cardio - Vascular Disease.	1 mo.
Due to Arteriosclerosis	Several years.
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: - - -
Date of op.
Autopsy results: - - -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Frank Shipley M.D.
Address: Savage, Md. M. D. or other
Date signed: 12/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10837

302

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Washington

City or town: Hagerstown, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 3 months & 15 days

Hospital, Institution, or street address where death occurred: Hagerstown State Hosp. Hagerstown, Md.

How long in hospital or institution? 1 year 3 months 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 278 N. Jonathan Street

(If rural, give LOCATION)

2(a) If veteran, name war:

3. (a) FULL NAME: Nutter (Clinton) Annie

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	unknown

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1918

8. AGE: Years	Months	Days	If less than one day
29			..... hrs. ..... min.

9. Birthplace: West Va. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: unknown

13. Birthplace:

MOTHER — 14. Maiden name: unknown

15. Birthplace:

16. Informant: Hospital Records

Address: Hagerstown, Md.

17. Burial, cremation, or removal. Which?: burial Date thereof: 12/15/47 (month) (day) (year)

Cemetery or crematory: Rosedale

Location: Hagerstown Md

18. Funeral director: Wm H. Downey

Address: 291 Frederick St Hagerstown Md.

19. 12/14 1947 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13th 1947 at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28th 1946, to December 13th 1947 and that I last saw h[illegible] alive on December 13th 1947

	DURATION
Immediate cause of death: General paresis	Known to us since admission August 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: Jacob Montgomery M.D. M. D. or other

Address: ..... Date signed .....

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c 10838

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G Meade, Maryland
(If outside city or town limits, writes RURAL and give nearest town)

How long in above place of death? 2 mos

Hospital, institution, or street address where death occurred:
Station Hospital Ft Geo G Meade, Md.

How long in hospital or institution? 2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Oklahoma County: Pontotoc

City or town: Ada
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #5
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES T. ODOM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 25 April 1929

8. AGE: Years	Months	Days	If less than one day
18	7	14	hrs. min.

9. Birthplace: Ada, Oklahoma
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business:

FATHER
12. Name: Unavailable
13. Birthplace:

MOTHER
14. Maiden name: Unavailable
15. Birthplace:

16. Informant: Service Records of deceased
Address: Ft Geo G Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 10 Dec 47 (month) (day) (year)

Cemetery or crematory:

Location: Ada, Oklahoma

18. Funeral director: Lilly & Zeiler, Inc
Address: 403 S. Wolfe St., Baltimore, Md.

19. 11 Dec 47 (Date rec'd by registrar) 20. JAMES N. GOERGER, Capt., MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 December 19 47, at 2125 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2030 hrs 9 December 19 47, to 2125 hrs 9 Dec 47 and that I last saw him alive on 9 December 19 47

Immediate cause of death	DURATION
Intracranial hemorrhage	2½ hrs
Due to: Fracture of base of skull	2½ hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto accident Date of: 9 Dec 47

Where did injury occur? Ft Geo G Meade, Md. (City or town) Anne Arundel (County) (State)

Injured at home, farm, industry, public place (where?): Annapolis & Mapes Road

Means of injury: Struck by auto Injured at work? No

23. SIGNATURE: Henry W. Foster 1st Lt, M.C.
HENRY W. FOSTER, 1st Lt., M.C., D.O. or other
Address: Ft Geo G Meade, Md. Date signed: 11 Dec 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10839

940

CERTIFICATE OF DEATH

Reg. Diat. No. 21

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Annapolis Hospital
How long in hospital or institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Le Roy Owens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14, 1928

8. AGE: Years	Months	Days	If less than one day
21	8	13	..... hrs. ..... min.

9. Birthplace: Parole, A. A. Co. Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Richard D. Owens
13. Birthplace: A. A. Co. Md.
MOTHER 14. Maiden name: Elsie Lane
15. Birthplace: A. A. Co. Md.
16. Informant: Richard D Owens
Address: Parole, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1947 (month) (day) (year)
Cemetery or crematory: Fowlers Chapel
Location: East Gate, Md.
18. Funeral director: J. B. Johnson
Address: Annapolis, Md. P. O. Box 462
19. Dec. 29 1947 (Date rec'd by registrar)
W. C. Branch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 27 1947, at 10 45 P. M.
21. I CERTIFY that death occurred on the date above stated: ~~That I attended deceased from~~ Asst. Medical Examiner
~~and that I last saw h~~ alive on ..... 19....
Immediate cause of death: Coronary occlusion — DURATION: Sudden
Due to: Coronary Sclerosis — DURATION: Unknown
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?
23. SIGNATURE: John M. Cluff M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed: 12/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1576

CERTIFICATE OF DEATH

10840

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: a a
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 hours
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 3 hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: a a
City or town: Camp Parole - A. A. Co (If outside city or town limits, write RURAL and give nearest town)
Street No.: No Street number (If rural, give LOCATION)
2.(a) If veteran, name war: not a Veteran

3.(a) FULL NAME: Leona Beatrice ~~Baby~~ Paddy (Female)
3.(b) Social Security Number:

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: ~~Della Paddy~~
6.(c) If alive, give age: ~~3 hours~~ years
7. Birth date of deceased (mo., day, yr.): Dec 1 - 47
8. AGE: Years — Months — Days — If less than one day: 2 hrs. 8 min.
9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: Child
11. Industry or business: Child
FATHER 12. Name: James Paddy
13. Birthplace: Camp Parole - A. A. Co
MOTHER 14. Maiden name: Della [illegible]
15. Birthplace: [illegible] - West Virginia
16. Informant: James Paddy
Address: A. A. Co
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-4-47 (month) (day) (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis, Maryland
18. Funeral director: Ben L. Hopping and Son
Address: 170-172 west St. Annapolis, Md.
19. Dec. 4, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1, 1947, at 5.10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1947, to Dec. 1, 1947
and that I last saw her alive on Dec. 1, 1947

Immediate cause of death	DURATION
Prematurity - 6½ mos duration of pregnancy	"
Due to (Unknown)	
Due to	
Other conditions: Officer defender (Cerebral [illegible]) (Include pregnancy within 3 months of death)	(Since birth)

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. (M.D. or other)
Address: Annapolis, Md. Date signed: 12/1/47

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

10841

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crownsville, State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Pittsfield
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Emma Parker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	negro	married

6.(b) Name of husband or wife: separated -unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Auggust 20, 1871

8. AGE: Years	Months	Days	If less than one day
66	3	15	hrs. min.

9. Birthplace: Pittsfield, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: Moses Farlow,

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Iona Johnson

MOTHER — 15. Birthplace: Maryland

16. Informant: Crownsville Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/47 (month) (day) (year)

Cemetery or crematory: Glass Hill

Location: Parsonsburg, Maryland

18. Funeral director: Booker W. Wess

Address: Parsonsburg, Maryland

19. Dec. 6, 1947 (Date rec'd by Registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5, 19 47, at 6:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
er Decm. 5, 1947, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Cerebral Arteriosclerosis	Known to us since 8/6/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other

Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942a

10842

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Parole Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
Parole Md. near Annapolis
How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole Md. near Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. Parole Md. near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war ----------

3.(a) FULL NAME: Harvey Edward Phillips

3.(b) Social Security Number: 214-05-1242

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elizabeth Olivia Phillips
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 24, 1902

8. AGE: Years	Months	Days	If less than one day
45	0	25	..... hrs. ..... min.

9. Birthplace: Annapolis Md. Anne Arundel Co.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: None

FATHER
12. Name: Benjamin Phillips
13. Birthplace: Baltimore, Maryland.

MOTHER
14. Maiden name: Cordelia Reed
15. Birthplace: Annapolis, Maryland

16. Informant: Elizabeth Olivia Phillips
Address: Parole Md. near Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-23-1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Dec. 22 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 20, 1947 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 13, 1947 to December 20 1947 and that I last saw him alive on December 20 1947

Immediate cause of death	DURATION
Cardiac Failure	1 wk.
Due to: Coronary Occlusion	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Herdine L. Johnson M.D. M. D. or other
Address: 40 Northwest Street Date signed 12/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 10843

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Howard E. Porter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 6, 1871

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
76	8	4		

9. Birthplace: A. A. Co., Maryland (Town, county, and state)

10. Usual occupation: painter

11. Industry or business

FATHER — 12. Name: unknown

13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Mrs. Frank J. Connell

Address: Edgewater, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/13/47 (month) (day) (year)

Cemetery or crematory: Mayo Memorial Cemetery

Location: Mayo, A. A. Co. Md.

18. Funeral director: John M. Tayton Son

Address: Annapolis, Md.

19. Dec. 11, 1947 (Date rec'd by registrar) W. O. Dossett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 1947 at 12:00 noon

21. I CERTIFY that death occurred on the date above stated: ~~that I last attended deceased on~~ Postmortem 1947 Examination Dec. 10 1947 ~~and that I last saw deceased alive on~~

Immediate cause of death	DURATION
Acute Dilatation of heart	Sudden
Due to: Ch. Cardio-Vascular disease	uncertain
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner (M. D. or other)

Address: Annapolis Md. Date signed: 12/11/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

10844

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, institution, or street address where death occurred: 9 Cypress Row
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Cypress Row
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Conelia Albert Ransom

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
72			... hrs. ... min.

9. Birthplace: Matthews County, Va. (Town, county, and state)
10. Usual occupation: Sailor
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Jannie Mouberry
Address: 9 Cypress Row

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1- 7- 1948 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Jan 7 48 (Date rec'd by registrar) W. D. Council Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30, 1947 at 7 40 A. M.

21. I CERTIFY that death occurred on the date above stated: Postmortem Examination

Dec. 30, 1947

Immediate cause of death	DURATION
Cardio-Vascular	
Due to: Renal Disease	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: John N. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 1-3-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

22 93d 10845

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Martin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maggie E. Scherger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Widow

6.(b) Name of husband or wife John F. Scherger
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 9th 1874

8. AGE:

Years	Months	Days	If less than one day
73	6	13	..... hrs. ..... min.

9. Birthplace Annapolis Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name John H. Jacobs
13. Birthplace Maryland

MOTHER
14. Maiden name
15. Birthplace

16. Informant Elwood B. Scherger
Address 2 Martin St Annapolis

17. Burial Date thereof 12/24/47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory National Cemetery
Location Annapolis Maryland

18. Funeral director John M. Taylor & Son
Address Annapolis Maryland

19. Dec. 23 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1947, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1947 to Dec 22 1947 and that I last saw her alive on Dec. 21 1947

Immediate cause of death	DURATION
Myocarditis chr. & Myocardial Insufficiency	Several years
Due to	
Due to	
Other conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Geo C Bond M. D. or other
Address Annapolis Md Date signed 12-23-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10846

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Van Buren St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ida Virginia Sherbert

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife: Stockett M. Sherbert

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 19th 1862

8. AGE:

Years	Months	Days	If less than one day
85	1	2	hrs. min.

9. Birthplace: Friendship, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: Unknown Wm Wilkinson
13. Birthplace: Unknown Md.

MOTHER
14. Maiden name: Mary Childs
15. Birthplace: Maryland

16. Informant: Mrs. R. Bernard Wagoner
Address: Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/24/47 (month) (day) (year)

Cemetery or crematory: Mt. Harmony Cemetery

Location: Calvert County Md.

18. Funeral director: John M. Taylor Sons

Address: Annapolis

19. Dec 23 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1947 at 6 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Dec. 22 1947

and that I last saw h.er alive on Dec. 22, 1947

Immediate cause of death	DURATION
(a) Acute Dilatation of the Heart	Immediate
Due to	
Due to	
Other conditions: Arteriosclerotic Cardio-Vascular Disease - 5 yr.	5 yr.

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson MD
M. D. or other

Address Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the additions made shown on.

G 113 12/5/47 p.c.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

832

10847

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 6 months, 14 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 year, 6 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2220 N. Howard
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: ALBERT SLOCUM

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown June 22, 1884

8. AGE: Years	Months	Days	If less than one day
63	?	?	hrs. min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business:

FATHER
12. Name: unknown John Slocum
13. Birthplace: unknown Md.

MOTHER
14. Maiden name: unknown Mary ?
15. Birthplace: unknown Md.

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal) Which?
Date thereof: Dec 6, 1947
(month) (day) (year)
Cemetery or crematory: M.E. Calvary Cem.
Location:

18. Funeral director: Mrs Katie R. Williams
Address: 322 N Schroeder St

19. 12/8 1947 A.W. Hedrick
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4th 1947 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20th 1946 to December 4th 1947 and that I last saw him alive on December 4th 1947

Immediate cause of death	DURATION
hemiplegia	5 days
Due to: Cerebral Arteriosclerosis	Known to us since 5/20/46
Due to:	
Other conditions: Psychosis With Cerebral Arteriosclerosis	Known to us since 5/20/46

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of:
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jean Marguerite M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 12/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

838 10848

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Gambrills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Gambrills

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME: Laura Elizabeth Smith

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Allen Smith

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Febuary 12 1884

8. AGE: Years	Months	Days	If less than one day
63	9	22	— hrs. — min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER — 12. Name: Joseph I Bowling

13. Birthplace: Baltimore Md

MOTHER — 14. Maiden name: Mary Vaughn

15. Birthplace: Baltimore Md

16. Informant: William Allen Smith

Address: Gambrills Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8 Dec. 1947 (month) (day) (year)

Cemetery or ~~crematory~~: Loudon Park

Location: Baltimore Md.

18. Funeral director: F. B. Wiskeart & Son

Address: 1300 Eutaw Place

19. 12/8 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1947, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947, to December 1947

and that I last saw h e r alive on December 4 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	10 Hrs
Due to Hemolytic Anemia	13 Months
cause undetermined	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward J Chenett M.D. M. D. or other

Address: Gambrills Md Date signed: Dec 4, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RN Anderson

W

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10849

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Ann Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 91 Smithville St. Spa Road, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Ann Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 91 Smithville St. Spa Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Madoline Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: John Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1880

8. AGE: Years	Months	Days	If less than one day
67	8	25	hrs. min.

9. Birthplace: Calvert Co. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER — 12. Name: Frederick Jones

13. Birthplace: Calvert Co.

MOTHER — 14. Maiden name: Annie Simms

15. Birthplace: Calvert Co.

16. Informant: John Simms

Address: 91 Smithville St. Spa Road, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9, 1947 (month) (day) (year)

Cemetery or crematory: Annapolis Neck

Location: Annapolis Neck, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md. P.O. Box 462

19. Dec 8, 1947 (Date rec'd by registrar)

W. O. Brunch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1947 to Dec. 5, 1947

and that I last saw h... alive on Dec. 5, 1947

Immediate cause of death: Acute Dilatation of the Heart — Duration: 2 days

Due to:

Due to:

Other conditions: Cervical Adenitis — Duration: 3 months

(Include pregnancy within 3 months of death)

Major findings of operations: Incision & drainage of neck on — Date of op. 10/22/47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other

Address: Annapolis, Md. Date signed: 12/4/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

80d 10850

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital.

How long in hospital or institution? 17 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Sudley

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Smith, Thomas.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	S.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 1939

8. AGE:

Years	Months	Days	If less than one day
8	2	23	hrs. min.

9. Birthplace: Md.

(Town, county, and state)

10. Usual occupation: Child.

11. Industry or business

FATHER

12. Name: Robert Smith

13. Birthplace: Harwood, Md.

MOTHER

14. Maiden name: Marcha Smith

15. Birthplace: West River, Md.

16. Informant: Robert Leon Smith

Address: Galesville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8, 1947 (month) (day) (year)

Cemetery or crematory: Dan'l Star Cem.

Location: West River, Md.

18. Funeral director: J. A. Hardesty & Son

Address: Galesville, Md.

19. Dec. 8, 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-5 1947 at 11 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-4 1947 to 12-5 1947

and that I last saw him alive on 12-5 1947

	DURATION
Immediate cause of death: Encephalitis	4 days
Due to: ? pertussis	
? TBC	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth Peabody Trenett M. D. or other

Address: 240 Prince George Date signed: 12.5.47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10851

932

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: C C 60
City or town: Silver Spring Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: C C
City or town: Silver Spring Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Marguerette B Snow

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femal.	White	Divorced

6.(b) Name of husband or wife: Julian

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 19. 1883.

8. AGE:

Years	Months	Days	If less than one day
64			..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Seamstress

11. Industry or business

FATHER
12. Name: George Snow
13. Birthplace: Md

MOTHER
14. Maiden name: Hester Ann Timmons
15. Birthplace: Md.

18. Informant: Evelyn Peters
Address: Silver Spring Park Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 23-1947 (month) (day) (year)
Cemetery or crematory: Parkwood
Location: Taylor Ave

18. Funeral director: John E Moran
Address: 3000 E Baltimore St

19. 12/21 1947 E. J. Dalba
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20. 1947 at 945 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1. 1947 to Dec 20 1947 and that I last saw h... alive on Dec 19. 1947

Immediate cause of death	DURATION
Cerebral Arterio-Sclerosis	2 yrs
Due to: Cardio. Vascular Disease	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James S. Bellingolia. M.D. M. D. or other
Address: Glen Burnie. Md Date signed Dec. 21, 1947

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21 — 10852

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Robinson Station

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Robinson Station

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jerome G. Stevens

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Elizabeth Stevens

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18th 1884

8. AGE:

Years	Months	Days	If less than one day
63	2	16	hrs. min.

9. Birthplace: A. A. Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER — 12. Name: Charles Stevens

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Malessa Jones

15. Birthplace: Maryland

16. Informant: Mrs. Elizabeth Stevens

Address: Robinson, A.A.Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/7/47 (month) (day) (year)

Cemetery or crematory: Baldwin Memorial Cemetery

Location: Seven Crossroads, A.A.Co. Md.

18. Funeral director: John M Tay Co. La

Address: Annapolis Md.

19. Dec 7 19 47 (Date rec'd by registrar) L. A. Bleistine Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/4/47 19 at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/8/46 19 to 12/4/47 19

and that I last saw h[illegible] alive on 12/2/47 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John C. Alexander M. D. of other

Address: Glen Burnie Md. Date signed 12/5/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

124 &

10853

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severna Park

(If outside city or town limits, write RURAL and give nearest town) Road

Street No. Old Annapolis Blvd. & Cypris Creek

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: STANLEY STREETT

3. (b) Social Security Number: N one

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret B. Street

Nee Miller

6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): September 17, 1947.

8. AGE: Years	Months	Days	If less than one day
60	2	25	..... hrs. ..... min.

9. Birthplace: Maltimore, Md. (Town, county, and state)

10. Usual occupation: Tavern Keeper

11. Industry or business: Own Business

FATHER — 12. Name: William Streett

13. Birthplace: Harford Co. Maryland

MOTHER — 14. Maiden name: Clara V. Snow

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Margaret B. Street

Address: Severna Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15 1947 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Dec. 15 1947 (Date rec'd by registrar) L. J. Healba per T Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12 1947 at 6.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1943, to Dec. 12 1947 and that I last saw him alive on 12/12/47 19....

Immediate cause of death: Carcinoma of the liver — DURATION: 2 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of .....

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: Gustave K. Rambusch M. D. or other

Address: Glen Burnie, Md. Date signed: 12/13/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

73d

10854

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH
County A. A. Co.
City or town Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No. Severn Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Silas A. Sybert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Late Anna M. Sybert
7. Birth date of deceased (mo., day, yr.) March 8th 1864 6.(c) If alive, give age ..... years

8. AGE: Years 83 Months 8 Days 27 If less than one day ..... hrs. ..... min.

9. Birthplace Carrollton Md
(Town, county, and state)
10. Usual occupation State Keeper
11. Industry or business Self
FATHER 12. Name Sebastian C. Sybert
13. Birthplace Germany
MOTHER 14. Maiden name Martha Bradley
15. Birthplace Frederick Co.
16. Informant Mrs. E. Sybert
Address 6700 Washington Blvd.
17. Burial (Burial, cremation, or removal, Which?) Date thereof 12/6/47 (month) (day) (year)
Cemetery or crematory St. Augustine Cem.
Location Baltimore, Md.
18. Funeral director John F. Gorman & Son
Address 4603 Gallows St.
19. 12/5 1947 A. B. Hebert Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1947, at 8 45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 3, 1947, to Dec. 4, 1947
and that I last saw h. alive on Dec. 4, 1947

	DURATION
Immediate cause of death Coronary Thrombosis	1 Wk.
Due to Myocarditis, Chronic	1 Yr.
Due to Arteriosclerotic Heart Disease	1 Yr.
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James R. Grantz M. D. or other
Address Annapolis, Md. Date signed 12-4-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46a

10855

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Years

Hospital, institution, or street address where death occurred:
Station Hospital Ft George G Meade, Md.

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Fort George G Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war ....

3.(a) FULL NAME

ELIZABETH B. THOM

3.(b) Social Security Number

---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Krauth W. Thom

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 2 September 1878

8. AGE: Years	Months	Days	If less than one day
69	3	2	....hrs. ....min.

9. Birthplace: Kentuck, Pittslyvania, Co., Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: -

FATHER
12. Name: John Thomas Bennett
13. Birthplace: Virginia

MOTHER
14. Maiden name: Eudora Snead
15. Birthplace: Virginia

16. Informant: Colonel Krauth Thom
Address: Fort George G Meade, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 4 Dec 1947 (month) (day) (year)

Cemetery or crematory: National Cemetery

Location: Arlington, Va.

18. Funeral director: Wm J. Tickner & Sons

Address: North & Penna Ave, Balto., Md.

19. 5 Dec 1947 (Date rec'd by registrar) James N. Goerger, Capt., MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 December 1947 at 0928 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 August 1947 to 4 December 1947 and that I last saw her alive on 4 December 1947

Immediate cause of death	DURATION
Congestive heart failure	1 mo
Due to: Fibrosis, pulmonary, due to X-ray therapy	6 mos
Due to: Hydrothorax, bilateral	2 wks
Other conditions: (1) Epidermoid carcinoma of esophagus. (2) Arteriosclerosis, generalized.	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. ....

Autopsy results: Pending

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Thomas W. Mattingly
THOMAS W. MATTINGLY, Lt Col., M.C
Address: Ft Geo G Meade, Md. Date signed: 5 Dec 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

10856

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address (if not in hospital or institution) where death occurred: Emergency Hospital

How long in hospital or institution? Pronounced Dead on Arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Rural, Mullberry Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John H. Tucker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 5, 1900

8. AGE: Years: 47 | Months: II | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: A.A.Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: John Henry Tucker; 13. Birthplace: Md.

MOTHER — 14. Maiden name: Eugiena Stansbury; 15. Birthplace: Md.

16. Informant: Robinson Tucker

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1947 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: Skidmore, Md.

18. Funeral director: J.B. Johnson

Address: Annapolis, Md. P.O. 362

19. Dec. 13 Thu 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 1947 at 8 a.m. A.M.

21. I CERTIFY that death occurred on the date above stated: ~~At the time stated.~~ Post Mortem Examination

~~examination~~ on Dec. 10 1947

	DURATION
Immediate cause of death	
Coronary occlusion	sudden
Due to	
Coronary sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis, Md. Date signed: 12-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

10857

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 19 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 1 month, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: KINSEY TURNER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Edith Turner
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 7-29-1888

8. AGE: Years	Months	Days	If less than one day
59	4	17 days	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Oysterman
11. Industry or business: None

FATHER
12. Name: John Turner
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Griffin
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12- 21-1947 (month) (day) (year)
Cemetery or crematory: Annapolis Neck Cemetery
Location: Annapolis Neck near Annapolis, Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Dec 19 1947 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16th 1947 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27th 1947 to December 16 1947 and that I last saw h... im alive on December 16th 1947

	DURATION
Immediate cause of death: General Paresis	
Due to: Known to us since 10/27/47	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of:
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D. M. D. or other
Address: Crownsville, Maryland Date signed: 12/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

180

10858-30

Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Oliver Turner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: about 45 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Anne Arundel County, Md (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER
12. Name: Alexander Turner
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Della Davis
Address: Galesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5 1947 (month) (day) (year)

Cemetery or crematory: Catholic Cem. Annex
Location: West River Rd
18. Funeral director: T. A. Hardesty & Son
Address: Galesville Md

19. 12/4/47 (Date rec'd by registrar) W. N. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1947 at 5 30 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~
Postmortem Examination 19
and that I last saw h~~im~~ alive on Dec. 3. 1947

Immediate cause of death	DURATION
Suffocation from	
Due to: fire in house	
Due to: ~~2nd~~ 2nd degree burns	
Other conditions: of hand & face	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 12-3-47
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John M. Caffey, M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed: 12-3-47

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10859

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:
County A A County
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A.A.
City or town Brooklyn Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 - First Ave - 25 Zone
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Mary Upton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.W.	Widowed

6.(b) Name of husband or wife James Frank Upton
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 8 - 1880

8. AGE: Years	Months	Days	If less than one day
67			hrs. min.

9. Birthplace A. A. Co Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name F. Green
13. Birthplace A A County Md
MOTHER 14. Maiden name
15. Birthplace A. A. County Md
16. Informant Mrs. John Thomas
Address 2 - First Ave Brooklyn PK
17. Buried (Burial, cremation, or removal. Which?) Date thereof 12/11/47 (month) (day) (year)
Cemetery or crematory Cedar Hill Cemetery
Location Jo. Ritchie Highway
18. Funeral director Milton Schilling
Address 3914 Hanover St - 25
19. Dec 9 1947 Ida M. Wheeler Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 - 1947, at 735 A. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1943 to Dec 8 1947
and that I last saw h... alive on Dec 8 1947

Immediate cause of death	DURATION
Coronary occlusion	
Due to Hypertension	
Due to	
Other conditions Diabetes Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ruby W Kuster M. D. or other
Address 302 Patapsco Ave Date signed Dec 9 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

10860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 14 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 2 years, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore - Turners Sta.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 809 Avondale Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: OSCAR WAKE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mattie Wake
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1876

8. AGE: Years	Months	Days	If less than one day
71	?	?	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Iceman
11. Industry or business:

FATHER
12. Name: Henry Wake
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Henry
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29, 1947 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial
Location:

18. Funeral director: Mrs Katie R. Williams
Address: 322 N. Schroeder St.

19. Dec 29 1947 (Date rec'd by registrar) C.W. Hellrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24th 1947 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 10th 1945 to December 24 1947 and that I last saw him alive on December 24th 1947

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 12/10/45
Due to:	
Due to:	
Other conditions: Senile Psychosis-Simple Deterioration (Include pregnancy within 3 months of death)	Known to us since 12/10/45

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jacob Thorpe M.D.
M. D. or other
Address: Crownsville, Maryland Date signed: 12/24/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10861

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mo. 14 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 yr. 1 mo. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 214 ~~Northwood St.~~ N. Wolfe St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANITA WILSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	negro	married

6.(b) Name of husband or wife: Louie Wilson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years	Months	Days	If less than one day
45			..... hrs. ..... min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER — 12. Name: Alfred Powell

FATHER — 13. Birthplace: Balto.

MOTHER — 14. Maiden name: Williemay Powell

MOTHER — 15. Birthplace: Balto

16. Informant: Hospital records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19-1947 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem.

Location: Brooklyn Md

18. Funeral director: Elroy D. Wilson

Address: 1000 Baltimore Ave

19. Dec 18 1947 (Date rec'd by registrar) J. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 14, 1947 19 47, at 4 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31 19 46 to Dec. 14 19 47 and that I last saw her alive on Dec. 14 19 47

	DURATION
Immediate cause of death: Cerebral Hemorrhage Known to us since	12/11/47
Due to: Cardio Renal Disease Known to us since	10/31/46
Due to:	
Other conditions: Known to us since	10/31/46

Psychosis with Cardio Renal Disease

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D. M. D. or other

Address: ..... Date signed .....

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92t

10862

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Marley Park - P.O. Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred: Greenway Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town: Same
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Margaret Matilda Wood.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: Warren R. Wood.
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): January 13 - 1892

8. AGE: Years: 55 | Months: 11 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: Rockhall - Kent County, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Ret

FATHER
12. Name: Richard Hodges
13. Birthplace: Eastern Shore, Md.

MOTHER
14. Maiden name: Minnie E. Downey
15. Birthplace: Kent County Md.

16. Informant: Mrs. W. C. Wood, husband
Address: Marley Park, P.O. Glen Burnie, Md

17. Burial (Burial, cremation, or removal, which?) Date thereof: DEC 26, 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 12/31/1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24 1947, at 11 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to 12/24 1947 and that I last saw her alive on 12/23/47 1947

Immediate cause of death	DURATION
Mitral Insufficiency	18 months
Due to: Hypertension	18 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Fawcett Md. M. D. or other
Address: Glen Burnie, Md Date signed: 12/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10863

1622

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 years

Hospital, institution, or street address where death occurred:
12 Murray Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 12 Murray Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Edward Woolley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Elizabeth Woolley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 27, 1860

8. AGE: Years	Months	Days	If less than one day
87	0	27	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Charles Carann Woolley
13. Birthplace: Md

MOTHER
14. Maiden name: Elizabeth Ann White
15. Birthplace: Md.

16. Informant: Mrs. Henry Ewert
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/47 (month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis Md.

18. Funeral director: John W. Layton Son

Address: Annapolis Md

19. Dec. 27 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1947, at 9 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9. 1947, to Dec. 25 1947 and that I last saw him alive on Dec. 24 1947

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D.
M.D. or other

Address: Annapolis Md. Date signed: Dec. 24, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15 9-45-15M